IRISH MEDICAL ORGANISATION

Ceardchumann Dochtúirí na hÉireann

IMO Submission to the Department of Health Consultation on the Draft Money Follows the Patient – Policy Paper on Hospital Financing

3rd May 2013

The Irish Medical Organisation (IMO) is the representative body for all doctors in Ireland and in its mission statement is committed to the development of a caring, efficient and effective health service. The IMO welcomes the opportunity to comment on the Draft Paper for Consultation "*Money Follows the Patient – Policy Paper on Hospital Financing*". The principles and values outlined in the paper resonate with the medical profession and ongoing consultation and engagement with the profession is needed to progress implementation.

The IMO supports a system of Money Follows the Patient (MTFP) which supports efficiency and transparency in the funding of health services.

Key concerns of the IMO include:

- The accuracy of data including the accuracy of coding in the HIPE system and the costing of DRGs;
- The ability of prospective case-based systems to capture the multiplicity and complexity of illnesses related to an ageing population, support future delivery models or cope with rapid changes in new technology and treatments;
- The imbalances created by
    - The exclusion of Primary Care Services from the MFTP system
    - Block funding of Emergency Department Services and other public hospital services
    - 'Per diem' charges to private patients in public hospitals;
- The impact of hospital groupings/Trusts
- Governance under the proposed model of Universal Health Insurance (UHI).

1. Establishing the Vision

The IMO supports the introduction of a Universal Health Care System and has laid out in the *IMO position paper on Universal Health Coverage* the following principles which should form the basis of a future universal health care system regardless of the model of financing.

IMO Principles of Universal Health Care
(See *IMO Position Paper on Universal Health Coverage - Apr 2010*).

- Access to adequate health care for all
- Services that are free at the point of access
- Equity of access
- Solidarity
- Transparency
- Quality of care and value for money
- Choice and mobility
- Clinical autonomy
- Efficiency
- Affordability
- Sustainability

Under the IMO principle of 'Efficiency' the IMO states that

> The flow of funds, from collection and pooling to purchasing, must be carried out efficiently. In the purchasing or provision of services money must follow the patient.
>
> *..Careful consideration must be given to the payment model. With case-based prospective payment systems, money appears to follow the patient. However they are not necessarily able to capture the multiplicity and complexity of illnesses related to an ageing population, support future delivery models (that is the transfer of many secondary services into a primary care setting) or cope with rapid changes in new technology and treatments.*[1]

The IMO notes that the Consultation Paper "*Money Follows the Patient – Policy Paper on Hospital Financing*" refers to the financing of public patients in public hospitals and does not refer to revenue raising or pooling of resources nor does it refer to the financing and purchasing of Primary Care services under a future UHI. While the hospital purchasing system can be considered independently of the financing and pooling mechanism, full details by way of a White Paper on UHI is needed for comprehensive commentary.

Neither does it address the funding of public health and health protection[2] which is typically poorly served by insurance-based funding systems.

"Although 'Money Follows the Patient' will start in hospitals, it is vital that money follows the patient to the most appropriate care setting. Therefore, while this paper maps out a policy framework to guide the initial introduction of a new model of funding within hospital settings, it does so in the full acknowledgement of wider reform plans for the strengthening of primary care, the creation of an integrated system of primary and hospital care, and the need for a funding model which continually evolves to support integrated, patient-centred care."

The IMO supports a financing system of Money Follows the Patient in non-hospital settings including Primary Care and General Practice. In order to ensure that patients are treated in the most appropriate setting and that services are not displaced from Primary Care back to the hospital setting, money must also follow the patient in Primary Care. A new GP contract which meets the needs of patients with acute and chronic illness must be a priority.

While a funding model is required to support the creation of an integrated system of primary and hospital care. There is a wide range of issues to be considered and addressed if the government is to deliver on its stated policy of providing integrated care to the population including: the effective use of Information and communications technology (ICT); the appropriate standardisation of care through the

[1] PricewaterhouseCooper's Health Research Institute, You Get What You Pay For – A Global Look at Balancing Demand, Quality, and Efficiency in Healthcare Payment Reform 2008

[2] This is a crucial area (relating to the management of infectious disease and environmnental threats and provision of health intelligence to ensure the effective mapping of health need and activity) which, if funding is not specifically earmarked, will become (potentially) catastrophically weakened, resulting in an inability to describe and address such areas as foodborne illness or outbreaks of vaccine preventable disease.

use of clinical guidelines; the effective management of resources (particularly in primary care) and the appropriate incentivising of care providers. (See *IMO Budget Submission 2013- Oct 2012*)

2. Understanding the Starting Point

2.2 Public Hospital System

Some Legislative changes will be required in order to introduce MFTP and to transfer responsibilities to the National Information and Pricing Office (NIPO) and the Healthcare Commissioning Agency (HCA).

2.4 Funding and Charging of Private Patients

Currently private patients in public hospitals are charged "per diem" rates for inpatient services according to hospital category and by private, semi-private and daycase status. This creates incentives for private health insurers to push patients requiring low cost elective care towards private providers where the cost-base is lower and charges more accurately reflect the level of treatment, while patients requiring cost intensive emergency, complex and chronic care are pushed towards the public hospital system.

For outpatient services private patients are charged consultant fees and fees for MRI Scans only. Hospital facility charges for private outpatients are effectively subsidised by the public system.

Private patients in public hospitals should be charged using the public hospital case-based DRG system.

2.7 Policy on Hospital Structures

Further details are required on the creation of Hospital Groups and the planned establishment of Hospital Trusts as well as the key principles and criteria set out in the "*Framework for Smaller Hospitals*". The IMO has reservations of the ability to create any real competition between hospital trusts under the Government's plan for UHI and would also welcome publication of the HRB *"International Evidence Review on Independent Hospital Trusts".*

3. Defining the Service

3.2 Efficiency and Quality – Comparing "like with like"

...if we wish to treat similar products in a similar way, then the 'Money Follows the Patient' payment system must encompass inpatient, daycase and certain comparable outpatient services.

A number of services are to be excluded from the 'Money Follows the Patient' payment system including

- Emergency Department Services
- Outpatient 'assessment' services
- Long-term care

- Outreach services
- Teaching services
- Research Costs

Emergency Departments (EDs) vary in cost and not all hospitals, particularly independent hospitals provide 24/7 arrangements. Accordingly the policy proposes to fund the provision of ED services by way of block grant however the document does not explain how ED services are to be costed. Currently the majority of hospital admissions (70%+) stem from the Emergency Department (ED). Funding elective procedures through a money follows the patient system and emergency services by block grant may create imbalances in the system and reducing necessary funding for emergency services. No risk analysis of this has been carried out. While not as easy to plan for and budget, it seems inevitable that ED will need to be funded according to activity.

It is proposed that outpatient assessment services should be financed separately. This fits well with the practice that has evolved in the private health sector in Ireland and reflects approaches adopted in other countries with comprehensive MFTP payment systems. Again the document does not indicate how outpatient assessment services are to be costed.

Outpatient services to private patients in public hospitals that are currently not charged must be charged to private patients (see section 2.4).

Teaching services: Under future hospital groupings there may be some loss of premiums to teaching hospitals as premiums will be averaged across the group. Some groups with more Band 1 hospitals may fair better. Funding for teaching services must adequately reflect current and future manpower and training requirements.

3.3 Efficiency and Quality – Encouraging care in the right setting

...Thinking must not remain anchored in funding facilities or settings but must shift to a concept of funding patient needs (i.e. complexity-adjusted episodes of care).

Not every patient will be amenable to treatment under an established DRG. The system must be able to identify and appropriately finance such patients.

...it is proposed that services should be defined by reference to the episode of care provided and not by reference to care setting to the greatest extent possible.

In order to ensure that patients are treated in the most appropriate setting and that services are not displaced from Primary Care back to the hospital setting, money must also follow the patient in Primary Care. A new GP contract which meets the needs of patients with acute and chronic illness must be a priority.

Clinical Guidelines and Healthcare Standards

…it is proposed that these guidelines (The national suite of clinical guidelines) should underpin the DRG payment system in terms of defining how a particular service should be delivered (i.e. a 'best practice' approach) and the corresponding costs associated with that best practice approach.

While clinical guidelines can contribute to quality care by standardising care across services there is a danger that, due to resource constraints or the time lag involved in the gathering of evidence and incorporating it into formal quality assured clinical guidelines, that guidelines may not be up to date nor result in the optimal clinical outcome. Clinical guidelines are also usually disease focused and thus designed to be applied to population groups with similar morbidity. As a result, they may not factor in co-morbidity or the impact of individual patient characteristics or choices.

Agreed clinical guidelines which underpin the DRG payment system should reflect international best practice, must be regularly updated and flexible to meet individual patient needs and choices.

3.4 Classification and Grouping System

..the HIPE system would be maintained as the standard classification and coding system on which future universal prospective payment systems would be built.

The IMO have some concerns about the accuracy of coding/data under the HIPE system. A recent study at St James's hospital showed significant discrepancies between HIPE data and the hospital's purpose designed vascular database (Vascubase) including the volume of procedures, duplication and miscoding and concluded that any attempt to use such data for service planning is flawed. [3] Similarly a study at Beaumont Hospital found a lack of compatibility between the HIPE coding and psychiatrists' coding of psychiatric disorders[4]. The HIPE coding failed to capture the complexity of patients and the level of activity undertaken by the Liaison Psychiatry Department with a potential for significant loss in revenue and distortion of the picture of clinical practice.

If the HIPE data is inaccurate, then funding will also be inaccurate. The result will be patient care following the money, instead of the opposite. The HSE and the ESRI must provide clear and transparent information in relation to how HIPE data is collated, measured and verified and some clinician input may be required.

3.5 Boundary Issues

…it is proposed that the episode of care under 'Money Follows the Patient' should begin at the point of admission and end when the patient is deemed medically fit for discharge.

The policy does not indicate how the delayed discharges, due to patients waiting for appropriate rehab, long-term care or supported community living, are to be funded.

[3] O'Callaghan et al. A Critical Evaluation of HIPE Data, *Ir Med J.* 2012 Jan; 105 (1):21-3
[4] Udoh G. Afif M. & MacHale S. The Additional Impact of Liaison Psychiatry on the Future Funding of General Hospital Services, *Ir Med J.* 2012 Nov-Dec; 105 (10):329-30

3.6 Mental Health

Mental Health services should not be excluded from the MFTP system. The HIPE system currently records data in relation to acute mental health services. With a review of the coding practices more accurate coding can be achieved.

4. Designing the Price

4.3 Calculating the Price

The calculation of the single price to be set for a cost weight (value) equal to 1 needs to be more explicit.

The accurate pricing of DRGs will be key. DRGs priced too cheaply will lead to 'dumping', 'skimping' and 'upcoding' while DRGs that are over-priced will lead to 'cream skimming' and 'gaming'. Some expertise in the pricing of care may be required. Pricing in the private system should not be relied upon as patients in private system and patients in the public system are not comparable.

4.4 Treatment of Costs

Pay Costs must be precise and factor in more than an annual salary. Under block grant funding a factor of 1.18 is applied to annual salary to cover official leave. All other professional costs associated with registration, CPD, travel, clinical indemnity cover, etc must be part of the calculation of pay costs.

It is unclear how costs associated with providing audit functions, patient safety, health and safety, occupational health, recruitment and induction are to be captured.

It should be noted that DRG payment systems are normally constructed to exclude medical professional charges. In the private healthcare market in Ireland consultant fees are also billed separately from hospital facility costs. In comprehensive health systems in other jurisdictions hospital and clinical decision maker financial interests are not aligned. The medical professional resources expended are calculated on the basis of a Resource Based Relative Value Scale (RBRVS) which is kept up to date has gained international traction and is the bible for health care insurers for use in assigning values for professional services. Separation of consultant fees in the public hospital payments system will have to be considered when moving to a Universal Health Insurance System.

Superannuation costs are to be excluded however there is a need to reflect the reality of Superannuation arrangements that operate in public hospitals.

Outlier cases are currently captured by the HIPE system therefore it should be possible to calculate the costs and provide for such cases.

5. Governance Structures

5.4 Structures for Delivering Interim Functions

Strict governance structures will be required if the Government is to achieve the policy goal of a universal health care system based on managed competition between public and private hospitals and between public and private health insurers (See IMO Position Paper on The Market Model of Health Care – *Caveat Emptor*). The National Information and Pricing Office (NIPO) and the Healthcare Commissioning Agency (HCA) are interim structures and the IMO would advise caution before relinquishing important functions to private health insurers.

Governing Process

5.5 Overview of Process

Given the imperative of retaining strict cost control over the system, 'Money Follows the Patient' will be introduced within a fixed budget envelope. The Minister will communicate details of this capped budget, the national pricelist and national service targets and priorities for public hospital services to the independent statutory purchaser, the Healthcare Commissioning Agency.

Service planning must be based on a realistic assessment of the likely number of patients who will need treatment and budgets must be then allocated accordingly. If services are rationed to fit the budget waiting lists will persist.

Given the experience of the US, the Netherlands and our own Private Health Insurance market, retaining strict control over costs will prove difficult in a universal healthcare system based on managed competition between public and private hospitals and between public and private health insurers (See *IMO Position Paper on The Market Model of Health Care – Caveat Emptor- Apr 2012*). Careful consideration must be given to how costs are to be controlled before the Government moves to such a model.

5.6 Setting and Approving the Price

A key principle underpinning the work of the Office would be that, at the hospital level, data should be collected and transmitted once but then used for multiple purposes by different strategic stakeholders.

Issues relating to confidentiality and the secondary use of data will need to be addressed through the long- awaited Health Information Bill.

5.7 Setting the Budget and National Service Priorities

Service planning must be based on a realistic assessment of the likely number of patients who will need treatment and budgets must be then allocated accordingly. If services are rationed to fit the budget waiting lists will persist. Again careful consideration must be given to how costs are to be controlled before the Government moves to the proposed model of UHI.

5.8 Agreeing Performance Contracts

Private activity is excluded from contracts with the purchasing agency (HCA) and detailed policy proposals in relation to private activity are not available for consultation. To comply with safety standards hospitals should not function at more than 85% of capacity and some 20% of that is excluded for private patients, the HCA should be informed that performance contracts should be established on the basis of 68% of hospital capacity.

Computerised waiting lists must be accurate as any error will lead to financial penalisation of hospitals.

5.9 Submission and Approval of Claims and Management of the Payment Process

Hospitals would be encouraged to achieve a maximum of 7 day turnaround times from date of discharge to date of claims submission.

Given the short timeframe payments may be submitted without sign off by the most responsible clinician. These should be transmitted to the clinician in parallel with the submission to the paying agency and an electronic sign off should be produced.

There is a need to specify a turnaround time for payment by the purchasing agency (HCA) that matches the suggested turnaround time for hospitals to submit claims.

5.11 Quality and Regulatory Mechanisms

The document rightly highlights the unintended consequences and perverse incentives associated with DRG systems including:

- *Dumping;*
- *Skimping;*
- *Cream skimming;*
- *Upcoding;*
- *Gaming.*

In order to ameliorate these perverse incentives the paper proposes the following policy measures:

- *Integrated Performance Management System;*
- *Auditing;*
- *Contracting process;*
- *Structured consultation and continuous updating of the system.*

Accurate data, including correct classification, exact pricing of conditions and proper length of stay guidelines, is key to addressing the unintended consequences and perverse incentives.

In a system based on managed competition between public and private hospitals and between public and private health insurers the unintended consequences and perverse incentives increase as private companies focus on profit-making and public and voluntary organisations are forced to compete. It is intended under the proposed model of UHI that the performance and contracting processes will be

taken over by the health insurers. The unintended consequences and perverse incentives will need to adequately addressed before moving to the proposed model.

6. Implementation

6.1 Core Building Blocks for 'Money Follows the Patient'

Price Formulation

The tools of MFTP – a coding classification system, a grouping system, patient level costing and price-setting – are all in place although some expertise and modification is needed to ensure accuracy of coding and pricing.

Claims Management

The electronic claims management is an absolute feature. Interfacing central and peripheral systems and trained staff are required. While the Department of Health must exercise caution before relinquishing some functions of the HCA, the function of claims management will be best suited to the private health insurers in the Government's proposed system of UHI. In the interim it may be worth contracting out this role.

6.2 Critical Dependencies

- *the development of a comprehensive financial management plan*
- *the creation of Hospital Groups,*
- *the transition of Vote management to the Department and*
- *the introduction of a sustainable mechanism for meeting the cost of private patients in public hospitals*

It is portrayed that each of the critical dependencies must be successfully concluded for MTFP to be sustainable, however none are critical to progress in developing MFTP and in reality are parallel agendas which may add features to/or enhance the MFTP system. Each of these independent agendas seem straight forward and none should become a stumbling block along a critical path to UHI.

7. Next Steps

7.1 Consultation

The strategy recognises that the cornerstone of implementation is ongoing communication. The implementation of MTFP requires the engagement of hospital clinical staff as well as management staff. The principles and values outlined in the paper resonate with the medical profession and ongoing consultation and engagement with the profession is needed to progress implementation. The IMO would welcome a meeting with the Department of Health to discuss the issues raised in the submission.

7.2 Future Evolution of Policy

The IMO supports a universal healthcare system based on the principles outlined in the *IMO position paper on Universal Health Coverage* calls on the Department of Health to engage with the IMO in the development of policy, system design and implementation of universal health insurance.

<u>IMO principle recommendations for Money Follows the Patient can be summarised as follows:</u>

Accurate coding and exact pricing are key to the success of Money Follows the Patient

- Accuracy of HIPE data is essential. The HSE and the ESRI must provide clear and transparent information in relation to how HIPE data is collated, measured and verified and some clinician input may be required;
- Clarification is needed on how the delayed discharges, due to patients waiting for appropriate rehab, long-term care or supported community living, are to be funded;
- Mental Health services should not be excluded from the MFTP system with a review of the coding practices more accurate coding can be achieved.
- The accurate pricing of DRGs will be key. Some expertise in the pricing of care may be required.
- Pay Costs to be included must be precise. Separation of consultant fees in the public hospital payments system will have to be considered when moving to a Universal Health Insurance System.
- There is a need to reflect the reality of Superannuation arrangements that operate in public hospitals.
- It should be possible to calculate the costs and provide for outlier cases.

Imbalances in the funding of health care services must be addressed

- Money must also follow the patient in Primary Care. A new contract which meets the needs of patients with acute and chronic illness must be a priority;
- Emergency Department services, teaching services and other excluded hospital services must be adequately costed;
- The DOH should consider that Emergency Departments will need to be funded according to activity;
- Private patients in public hospitals should be charged using the public hospital case-based DRG system;

The MFTP systems must be able to capture the multiplicity and complexity of illnesses related to an ageing population, support future delivery models or cope with rapid changes in new technology and treatments;

- Not every patient will be amenable to treatment under an established DRG. The system must be able to identify and appropriately finance such patients;
- Agreed clinical guidelines which underpin the DRG payment system should reflect international best practice, must be regularly updated and flexible to meet individual patient needs and choices;

The impact of Hospital groupings must be known

- Further details are required on Hospital Groups as well as the Framework for Smaller hospitals and the HRB "International Evidence Review on Independent Hospital Trusts"

Governance issues must be addressed before moving to the proposed model of Universal Health Insurance (UHI)

- Issues relating to confidentiality and the secondary use of data will need to be addressed through the long- awaited Health Information Bill.
- The Minister for Health should publish the White paper on Universal Health Insurance;
- Careful consideration must be given to how costs are to be controlled before the Government moves to the proposed model;
- Accurate data, including correct classification, exact pricing of conditions and proper length of stay guidelines, is key to addressing the unintended consequences and perverse incentives.
- The unintended consequences and perverse incentives must be adequately addressed before moving to the proposed model of UHI.

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